



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

KEVIN A. WILLIAMS, MD

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-17-1862-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

FEBRUARY 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received your EOB denying our claim for not documenting the injections given to this patient, however this is not true. It says on the office visit notes that the patient was injected with 10cc of lidocaine and cortisone. I would appreciate it if you would reprocess our claim."

Amount in Dispute: \$345.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT Code 20610...does not provide complete documentation for review... documentation does not support code 99212-25 as a separately identifiable procedure....HCPCS Codes J1040 and J2001 denied as documentation in report is insufficient to review."

Response Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2016	CPT Code 20610 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	\$220.00	\$0.00
	CPT Code 99212-25 Office Visit	\$75.00	\$0.00
	HCPCS Code J1040 Injection, methylprednisolone acetate, 80 mg	\$35.00	\$0.00
	HCPCS Code J2001 Injection, lidocaine HCl for intravenous infusion, 10 mg	\$15.00	\$0.00
TOTAL		\$345.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, requires in the absence of an applicable fee guideline, medical reimbursement shall be fair and reasonable.
4. The services in dispute were reduced/denied by the respondent with the following reason code:
 - X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.
 - Z652-Recommendation of payment has been based on a procedure code which best describes services rendered.
 - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
 - X358-Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.
 - W3-Additional payment made on appeal/reconsideration.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly the first time.

Issues

1. Does the documentation support billing CPT code 20610? Is the requestor entitled to reimbursement?
2. Does the documentation support billing CPT Code 99212-25? Is the requestor entitled to reimbursement?
3. Does the documentation support billing HCPCS code J1040? Is the requestor entitled to reimbursement?
4. Does the documentation support billing HCPCS code J2001? Is the requestor entitled to reimbursement?

Findings

28 Texas Administrative Code §134.203(b) states “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers...”

On the disputed date of service, the requestor billed the following codes:

- 20610-Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance.
- 99212-25- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
- J1040- Injection, methylprednisolone acetate, 80 mg.
- J2001-Injection, lidocaine HCl for intravenous infusion, 10 mg.

The respondent denied reimbursement for these codes based upon a lack of documentation to support the billed service.

Per Medicare's 1995 Documentation Guidelines For Evaluation And Management Services, (II)(7) titled General Principles of Medical Record Documentation:

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's

status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

(7) The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

The division reviewed the submitted documentation and finds the following:

1. Does the documentation support billing CPT code 20610?

Per CCI Edits Manual Chapter 4, (G), (7), "CPT codes 20600-20611 are a family of codes describing arthrocentesis for aspiration and/or injection of different sized joints or bursae with or without ultrasound guidance. The unit of service (UOS) for each of these codes is a joint and its surrounding bursae, if any. A physician should not report more than one (1) UOS for arthrocentesis of any one joint regardless of whether or not the physician also aspirates or injects one or more of its surrounding bursae. For example, if a physician performs arthrocentesis of the shoulder and two bursae of the same shoulder without ultrasound guidance, only 1 UOS of CPT code 20610 may be reported."

The requestor wrote "Plan: Procedure Codes: 20610 ARTHROCENTESIS ASPIRATION/INJ MAJOR JOINT."

The division finds that the requestor did not sufficiently support billing code 20610 because the record does not detail the procedure, such as: which major joint or location was injected, findings, or the claimant's reaction to treatment. As a result, reimbursement is not recommended.

2. Does the documentation support billing CPT code 99212-25?

Per CCI Edits Manual Chapter 4, (B) "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles."

Code 20610 has a global period of 000 days and is considered a minor surgical procedure. A review of the submitted documentation does not support a "significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25"; therefore, reimbursement is not recommended.

3. Does the documentation support billing CPT code J1040?

The requestor wrote, "Notes: inj with 10cc lido/cortisone." This statement does not sufficiently support billing HCPCS code J1040. As a result, no reimbursement is recommended.

4. Does the documentation support billing CPT code J2001?

Per CCI edits, code J2001 is included in code 20610; however, a modifier is allowed to differentiate the service. A review of the submitted bill finds that the requestor did not use a modifier to differentiate the service; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	3/9/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.